County of Los Angeles - Department of Mental Health Office of the Medical Director Medi-Cal Professional Services and Authorization Division

Provider Relations Unit

PROVIDER NUMBER IS MISSING OR INVALID 2] RECIPIENT NUMBER IS MISSING OR INVALID 3] BSX CODE IS MISSING OR INVALID 4] PROOR AUTHORIZATION NUMBER IS INVALID 5] DATE OF SERVICE IS MISSING OR INVALID 7] PIACE OF SERVICE IS MISSING OR INVALID 8] COLAMITY IS MISSING OR INVALID 9] PROCEDIENT MISSING SINGHAM INVALID 10] THE BEGIN SERVICE IS MISSING OR INVALID 11] LA CO RECIPIENT MISSING OR INVALID 12] PROVIDER SIGNATURE IS MISSING OR INVALID 13] HOSPITAL PROOR AUTHORIZATION NUMBER IS INVALID 14] CICAMI RECEIVED AFTER THE ONE YEAR BILLING LIMITATION 15] CILAMIR CON ON AUSISTMENT IS INVALID 16] CILAMIR RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CLAIM WITH A LATE BILLING INDICATOR 17] FORMER CON ON AUSISTMENT IS INVALID 18] CILAMIR RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CLAIM WITH A LATE BILLING INDICATOR 19] CILAMIR RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CLAIM WITH A LATE BILLING INDICATOR 19] CILAMIR RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CHARLES IN A LATE BILLING INDICATOR 19] CILAMIR RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CHARLES IN A LATE BILLING INDICATOR 10] BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 10] BILLING PROVIDER NUMBER IS NOT FOUND ON THE LAC OPPOVIDER FILE FOR DATE OF SERVICE 10] RENDERINGSTAFF PROVIDER NUMBER IS NOT FOUND ON THE LAC OO PROVIDER FILE FOR DATE OF SERVICE 110] RENDERINGSTAFF PROVIDER SINGT SON THE PROVIDER THE BILLING GROUP PROVIDER FILE FOR DATE OF SERVICE 110] RENDERINGSTAFF PROVIDER SINGT REGISTERED TO PROVIDER FILE SINGALID FOR DATE OF SERVICE 110] RENDERINGSTAFF PROVIDER SINGT SON THE CLAO OPPOVIDER FILE FOR DATE OF SERVICE 110] RENDERINGSTAFF FOR OWNER OF THE PROVIDER THE MISSINGTORY HAS BELLING FOR DATE OF SERVICE 110] RENDERING HAS A NON-FEDERAL AND COSE NOT MATCH THE MISSINGTORY HAS BELLING FOR DATE OF SERVICE 200] RECIPIENT HAS A NON-	CCCT #	Transfer (Transfer (Transfer Court
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17 FORMER CON ON ADJUSTMENT IS INVALID 18 DATE OF SERVICE IS GREATER THAN THE JULIAN DATE OF CON 19 CLAIM RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CLAIM WITH A LATE BILLING INDICATOR 20 LINE AMOUNT (CHARGES) IS INVALID (LESS THAN \$10.00) 20 LINE AMOUNT (CHARGES) IS INVALID (LESS THAN \$10.00) 100 BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE 101 BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE 102 BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 103 RENDERING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 104 RENDERING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 105 RENDERING PROVIDER TYPE IS NOT RELATED TO THE BILLING GROUP PROVIDER TYPE 106 RENDERING/STAFF PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 107 RENDERING/STAFF PROVIDER STATUS ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 108 RENDERING/STAFF PROVIDER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 109 RENDERING/STAFF PROVIDER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE 100 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE 201 RECIPIENT HAS MIDDICARE COVERAGE ON DATE OF SERVICE 202 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE 203 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 205 RECIPIENT NUMBER IS NOT FOUND ON THE DESTRICES 206 RECIPIENT NUMBER IS NOT FOUND ON THE LA CO PROVIDER ON THE LA CO MIS FILE 207 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA COME SERVICE 208 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA COME SERVICE 209 RECIPIENT NUMBER IS NOT FOUND ON THE LA COME SERVICE 200 RECIPIENT NUMBER IS NOT FOUND ON THE LA COME SERVICE 201 RECIPIENT NUMBER IS NOT FOUND ON THE LA COME SERVICE 202 RECIPIENT NUMBER ON DATE OF SERVICE 203 RECIPIENT NUMBE	16	CLAIM RECEIVED AFTER THE SIX MONTH BILLING LIMITATION
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110 RENDERING/STAFF PROVIDER IS NOT REGISTERED TO PROVIDE SERVICES WITH THIS BILLING PROVIDER 111 PLACE OF SERVICE IS NOT VALID FOR THE PROVIDER TYPE 200 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE 201 RECIPIENT IS NOT ELIGIBLE ON DATE OF SERVICE 202 RECIPIENT MIS NUMBER ON CLAIM DOES NOT MATCH THE MIS NUMBER ON THE LA CO MIS FILE 203 RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES 204 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE 205 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	109	RENDERING/STAFF PROVIDER STATUS ON THE LA CO PROVIDER FILE IS INVALID FOR DATE OF SERVICE
111 PLACE OF SERVICE IS NOT VALID FOR THE PROVIDER TYPE 200 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE 201 RECIPIENT IS NOT ELIGIBLE ON DATE OF SERVICE 202 RECIPIENT MIS NUMBER ON CLAIM DOES NOT MATCH THE MIS NUMBER ON THE LA CO MIS FILE 203 RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES 204 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE 205 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	110	RENDERING/STAFF PROVIDER IS NOT REGISTERED TO PROVIDE SERVICES WITH THIS BILLING PROVIDER
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201 RECIPIENT IS NOT ELIGIBLE ON DATE OF SERVICE 202 RECIPIENT MIS NUMBER ON CLAIM DOES NOT MATCH THE MIS NUMBER ON THE LA CO MIS FILE 203 RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES 204 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE 205 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	200) RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE
202 RECIPIENT MIS NUMBER ON CLAIM DOES NOT MATCH THE MIS NUMBER ON THE LA CO MIS FILE 203 RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES 204 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE 205 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	201	I RECIPIENT IS NOT ELIGIBLE ON DATE OF SERVICE
203 RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES 204 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE 205 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	202	CO MIS FI
204 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE 205 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	203	RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES
205 RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE 206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	204	1 RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE
206 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	205	5] RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE
	206	6 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER

	706 DISCHARGE SUMMARY IS NOT PAYABLE WHEN BILLED WITH A HOSPITAL VISIT	
	705 THE PROCEDURE CODE BILLED EXCEEDS THE OCCURRENCES APPROVED ON THE LA CO PRIOR AUTHORIZATION FILE	
	704 PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE	
	703 THIS IS A POSSIBLE DUPLICATE OF A PREVIOUS CLAIM	
	702 THIS IS AN EXACT DUPLICATE OF A PREVIOUS CLAIM	
	701 THE ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT	
	700 NO HISTORY WAS FOUND FOR THIS ADJUSTMENT	
	NO NAME BECAUSE OF NO ELIGIBILITY. EXAMINER WILL ENTER THENAME FROM THE CLAIM.	
502	602 EMERGENCY CLAIM REQUIRES AN 'Y' IN THE EMERGENCY CLAIM INDICATOR FIELD WHEN USING POS 23 FOR PC 99284 OR X9500 OR X9502	
	601 EMERGENCY CLAIM REQUIRES A PROCEDURE CODE OF 99284 OR X9502 OR X9500 WHEN USING POS 23	
	600 MEDI-CAL FEE-FOR-SERVICE CLAIM IS NOT PAYABLE BY LA CO LMHP	
	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM	
-	538 HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 2 MORE WEEKS	
	537 HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 3 MORE WEEKS	
	536 HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 4 MORE WEEKS	
	535 HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 5 MORE WEEKS	
	LA CO HPA FILE	
	H	
	- THE CLAIM	
	- THE CLAIM	
	521 DATE OF SERVICE ON THE CLAIM DOES NOT MATCH THE DATE OF SERVICE ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE	
	520 HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE	
	505 PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE - THE CLAIM WILL RECYCLE	
	504 DATE OF SERVICE ON THE CLAIM DOES NOT MATCH THE DATE OF SERVICE ON THE LA CO PRIOR AUTHORIZATION FILE	
	503 PROCEDURE CODE ON THE CLAIM DOES NOT MATCH THE PROCEDURE CODE ON THE LA CO PRIOR AUTHORIZATION FILE	
	502 PROVIDER NUMBER ON THE CLAIM DOES NOT MATCH THE PROVIDER NUMBER ON THE LA CO PRIOR AUTHORIZATION FILE	
	501 RECIPIENT NUMBER ON THE CLAIM DOES NOT MATCH THE RECIPIENT NUMBER ON THE LA CO PRIOR AUTHORIZATION FILE	
	500 PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE	
	403 SECONDARY DIAGNOSIS CODE IS INVALID FOR AGE OF RECIPIENT	
	402 SECONDARY DIAGNOSIS CODE IS NOT FOUND ON THE LA CO DIAGNOSIS FILE	
	401 PRIMARY DIAGNOSIS CODE IS INVALID FOR AGE OF RECIPIENT	
	309 AN ORGANIZATIONAL PROVIDER PROCEDURE CODE BILLED ON OR AFTER SEPT. 1. 2000 WAS USING THE OLD RATE	
	308 PROCEDURE CODES 99222 AND 99232 CANNOT BE BILLED WITH A PLACE OF SERVICE 22	
	307 RENDERING PROVIDER IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED	
	306 RENDERING/STAFF PROVIDER IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED	
	305 PROCEDURE CODE IS AN INVALID ORGANIZATIONAL PROVIDER SERVICE	
	304 PROCEDURE CODE REQUIRES AN LA CO PRIOR AUTHORIZATION NUMBER	
	303 PROCEDURE CODE IS INVALID FOR AGE OF RECIPIENT; JUSTIFICATION REQUIRED	
	302 THE PROVIDER OF THIS SERVICE IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED	
	301 PROCEDURE CODE IS NOT FOUND ON THE LA CO PROCEDURE FILE FOR DATE OF SERVICE	
	300 PROCEDURE CODE IS NOT FOUND ON THE LA CO PROCEDURE FILE	
	207 RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER	
	CODE # MENTAL HEALTH FEE-FOR-SERVICE (MHFFS) EDIT/DENIAL CODES	COD

980 LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT QUANTITY	980
979 LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT AMOUNT PAID	978
978 LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT MEDS ID	978
977 LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT DATE OF SERVICE	977
976 LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT PROCEDURE CODE	976
975 LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT RENDERING PROVIDER	975
974 LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT BILLING PROVIDER	974
973 LA COUNTY MENTAL HEALTH PROVIDER INITIATED ADJUSTMENT AS A RESULT OF AN UNDERPAYMENT	973
972 LA COUNTY MENTAL HEALTH PROVIDER INITIATED ADJUSTMENT AS A RESULT OF AN OVERPAYMENT	972
971 LA COUNTY MENTAL HEALTH PAYMENT VOID	971
908 PAYMENT REDUCED BECAUSE OF PATIENT LIABILITY (SHARE OF COST)	908
906 PAYMENT REDUCED BECAUSE OF OTHER INSURANCE PAYMENT	906
902 ALLOWED	902
QUANTITY BILLED EXCEEDED MAXIMUM ALLOWED BY LA COUNTY MENTAL HEALTH; PROCESSED AMT ADJUSTED TO MAXIMUM QUANTITY	
PROCESSED AMOUNT ADJUSTED TO MAXIMUM ALLOWABLE	901
811 THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY PAID TO A RENDERING PROVIDER FROM 7-1-02 TO 9-30-02	811
810 THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 200. 201. OR 205 DENIAL FROM 2-1-02 TO 4-19-02	810
809 THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 303 DENIAL FROM 11-15-99 TO 5-1-00	809
808 THIS CLAIM REPROCESSES A CLAIM WITH A 90811 PROCEDURE CODE THAT PREVIOUSLY RECEIVED A 301 DENIAL FROM 1-17-00 TO 4-21-00	808
THIS CLAIM REPROCESSES A CLAIM BILLED FOR MULTIPLE UNITS BUT PAID FOR A QUANTITY OF ONE	807
806 THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 305 DENIAL	806
THIS CLAIM REPROCESSES A CLAIM WITH A VALID HPA NUMBER THAT PREVIOUSLY RECEIVED A 520 DENIAL	805
804 THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED (WITH AN 011 OR 202) FROM 11-15-99 TO 2-1-00	804
803 THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED (WITH A 103 OR 204) FROM 11-15-99 TO 1-7-00	803
ONLY ONE SERVICE IS ALLOWED PER DAY DURING AN INPATIENT HOSPITAL STAY FOLLOWING THE DAY OF ADMISSION	710
708 SELECTED PSYCHIATRIC SERVICES LIMITED TO 8 VISITS IN A 4 MONTH TRIMESTER WITHOUT AN APPROVED LA CO PRIOR AUTHORIZATION	708
707 HOSPITAL VISIT IS NOT PAYABLE WHEN BILLED WITH A DISCHARGE SUMMARY	707
MENTAL HEALTH FEE-FOR-SERVICE (MHFFS) EDIT/DENIAL CODES	CODE #

KSJ:ksj 3/18/2008

DENIAL REASONS	RULE #	DENIAL	DESCRIPTION/RESOLUTION
		DESCRIPTION	
Verify FFS Medi-Cal Payer	Inb837.Post.31	Medi-Cal was not sent	Medi-Cal was not sent FFS Network Provider must ensure that on the "Payer" tab "Medi-Cal" is
		as the payer.	selected with a check mark. If not, proceed to check it and enter the EVC
			number from the Medi-Cal eligibility response. There should be 2 green
			checks in the workspace on the Client Tab. Additionally, there should be no
			open circle or red "X" in the "M" (Medi-Cal) column. If there is an open circle
			or red "X" in the "M" column, then according to the State Medi-Cal Eligibility
			Determination System (MEDS) there is no eligiblity for the client (check for
			typographical error in the client index number [CIN] and perform a new
			eligibility check. Ensure Medi-Cal is selected with a check mark and 2
			green checks appear in the workspace on the Client Tab) and FFS Network
			Provider will need to work with client and/or Department of Social Services
	9		to obtain eligibility.
Client ineligible for service	Eligibility Check	Client is not enrolled	FFS Network Provider must verify that client is eligible (ensure there was no
	200	and/or DMH Client	typographical error in CIN # and if so perform a new eligibility check and
		I.D. # is invalid or not	submit a new claim) for service with Medi-Cal and/or Medicare. Perform a
	an.	eligible for services.	new eligibility check ensuring that there are two green checks in both "D"
			and "M" columns. Click on the green check in the "D" column and select
			"Update Enrollment" or "Enroll Client." Enter requested data in the data
			fields. Proceed to enter a new claim.

Check for Dup claim Inb837.Post.4	Verify Diagnosis Code Inb837.Post.37	Verify FFS Procedure & Inb837.Post.33 Service Time	DENIAL REASONS RULE #
Duplicate claims were submitted in EDI/SFT (not DDE) transmission.	Diagnosis code is incorrect or not valid	33 Procedure code and/or service time is incorrect.	DENIAL
This denial affects EDI/SFT (Electronic Data Interchange) users. This error should not occur with DDE (Direct Data Entry) users (those who access the IS system via webpage). Ensure that the patient account number (2300_CLM01) is unique across all claims submitted by a single EDI/SFT submitter/sender.	FFS Network Provider must verify that the diagnosis code was valid (minus typographical errors), payable by the Local Mental Health Plan and is the appropriate code to be used with the procedure code and service time. The HIPAA-compliant ICD 9 diagnosis codes to be used in the Integrated System may be downloaded from the following website address: http://dmh.lacounty.info/hipaa/downloads/IS_DIAG_CODES_TABLE_FOR_FFS.pdf.	FFS Network Provider must verify that the procedure code is correct for client (i.e., age, service time etc.). The procedure code service time must be reflected in minutes and not units, i.e., the "service unit amount" is within the appropriate range of the published guidelines (refer to the Guide to Procedure Codes for Claiming Specialty Mental Health Services: http://dmh.lacounty.info/hipaa/downloads/PROCEDURE_CODES_MANUAL.pdf). The FFS Network Provider must claim with procedure codes/services applicable to their specific taxonomy. If all of the above was performed and denials continue to occur, notify the Provider Relations Unit at (213) 738-3311 so they may research the denial to determine the problem. The Provider Relations Unit's troubleshooting efforts may include: (1) Verifying whether the Provider's IS and/or license/contract record(s) may be expired. (2) Verifying whether the Provider's taxonomy is expired. (3) Verify whether the Provider's IS records are missing taxonomy or other procedure code conversion data.	DESCRIPTION/RESOLUTION

				
Verify FFS 2 Rendering Provider Taxonomy		Verify Billing and Pay To Prov		DENIAL REASONS Verify Procedure Code
Inb837.Post.29	Inb837.Post.35	Inb837.Post.7		RULE# Inb837.Post.27
Providers discipline (i.e., MD, Phd, MFT) is incorrect or more than 1 taxonomy was used.	The service date on the claim was more than 6 months from the date the service was rendered and a delay reason code was missing or not valid for the FFS Network Provider.	IS Billing and/or Pay to Provider is not in the IS and/or FFS Network Provider is not active on the service date.	Salid in 18	DENIAL DESCRIPTION Procedure code is not
Contact the Providers Relations Unit, as staff will need to proceed as follows: (1) The Provider's IS license/contract record(s) may be expired and may need to be updated. (2) The Provider's taxonomy may be invalid. (3) The Provider's IS record may be expired, missing taxonomy or other procedure code conversion data. The Provider Relations Unit must update the providers' records and ensure that there is only one entry for the taxonomy.	Refer to the IS Codes Manual to obtain the latest version of the Late Codes (Delay Codes [page 840]) at the following website address: http://dmh.lacounty.info/hipaa/downloads/IS_CODES_MANUAL.pdf.	There must always be a Billing Provider on the transaction. This provider must exist in the IS and be active on the service date of the claim. This provider must be authorized in the IS to be a billing provider. There may also be a Pay-To-Provider, which has to be authorized in the IS. (For SFT/EDI submitters, double check that Billing and Pay-To-Providers' IDs are correct). Contact the Providers Relations Unit if futher assistance is needed.	Mental Health Services: http://dmh.lacounty.info/hipaa/downloads/PROCEDURE_CODES_MANUAL.pdf). If the appropriate procedure code was used and this denial continues to occur, notify the Provider Relations Unit so they may further research the denial. Reasons why denials may need to be researched by the Provider Relations Unit are as follows: (1) The Provider's IS and/or licensing/contract record(s) may be expired. (2) The Provider's taxonomy may not be appropriate for the service. (3) The Provider's IS record may be expired, missing taxonomy or other procedure code conversion data.	DENIAL DESCRIPTION/RESOLUTION DESCRIPTION Procedure code is not FFS Network Provider must ensure that the procedure code exists in the IS

DENIAL REASONS	RULE #	DENIAL	DESCRIPTION/RESOLUTION
		DESCRIPTION	
Verify Single Service	Inb837.Post.25	More than 1 service	Verify that there is only 1 service line per claim. If not, enter one service
		was entered on the	line per claim and re-enter a new claim. This denial pertains more to
		claim line.	
Verify Medi-Cal Medicare ID Inb837.Post.39	Inb837.Post.39	Medi-Cal or Medicare	If Medi-Cal is specified as a payer, ensure that the clients Medi-Cal ID is in
		ID is incorrect.	the CIN format - 8 digits and a letter (e.g. 12345678A). If Medicare is
			specified as a payer ensure the client's Medicare ID is in the format with a
			minimum of 9-digits and a max of 12-digits (e.g. A12345678XYZA).
Reject Corrected and	Inb837.Post.2	Corrected and/or	The IS will process only one (1) original or eight (8) voided claims. This
Replacemt		replacement claims	error message will be received when the re-submit button in the Claim Tab
		were rejected.	has been selected. It is recommended these claims be re-entered as if they
Verify Medicare and	Inb837.Post.17	No amount paid was	These providers submit claims to Medicare and other insurance before
Insurance		entered.	submitting the claim to DMH. Therefore, if Medicare or other insurance are
			cases where Medicare is referenced as a payer, if the amount paid loop
			exists, the paid amount should equal to \$0.00. If other insurance is
Daniel Charles	15-15-15-15-15-15-15-15-15-15-15-15-15-1	5	referenced as payer, IS will reject the claim.
Prev Resub Status For	Inb837.Post.5c	The "Resubmit"	Resubmitted claims must have original claims that have already been
Kesub		button was selected	denied. Ensure all resubmitted claims reference the original (initial) claims
		for a claim that was	and that the original (initial) claims have been denied.
		never denied.	
Verify Late Claims for Delay	Inb837.Post.19	There was no delay	Claims filed more than 6 months after the service date, must include an
reason code	2227	reason code	appropriate delay reason (late) code. Refer to the IS Codes Manual to
		submitted in the	obtain the latest version of the Late Codes (Delay Codes at the following
		electronic claim or it	website address:
		was invalid.	http://dmh.lacounty.info/hipaa/downloads/IS_CODES_MANUAL.pdf.
Verify Service Date to	Inb837.Post.28	Service date is more	The service date was submitted with a date that was more than 1 year
Current Date		than 1 yr before the	before the current date of submitting the claim and the claim was rejected.
		current date.	Dates of service more than 1 year from the date a service was rendered or
			submitted in the IS will be rejected.
Verify Subscriber Enrollment Inb837.Post.10	Inb837.Post.10	Subscriber ID # is	Verify the subscriber is enrolled with DMH. Ensure that the subscriber ID is
		invalid and/or	valid.
		Subscriber is not	
		enrolled w/ DMH.	

"Find Client" feature in the IS to locate the client's correct DMH Client ID.	not valid.		Deam
	Client service date	Inb837.Post.15	Verify service date to date of Inb837.Post.15
needed.			
users. Contact the EDI/SFT Technical Support Group if more details are			
This denial pertains more to SFT/EDI user. This should not occur with DDE			
the payer is not Medi-Cal or Medicare it is assumed to be private insurance.	insurance.		
	Medi-care or Private		
થી, insurance is valid. If the insurance type is Medi-Cal, it should be 'MC' and if	is invalid for Medi-Cal,		
Verify that the Insurance type code for Medi-Cal, Medicare or Private	Insurance type code	Inb837.Post.49	Verify Insurance Type Code Inb837.Post.49
denied, including the original, before submitting a void.			
resubmitted claim cannot be denied and all the others must have been			
void. If there is an original and one or more submitted claims, the last	be Voided.		
A denied claim cannot If there is only 1 original claim it must not be denied before submitting a	A denied claim canno	Inb837.Post.5b	Original/Resub Status For
200.0	illivalid of flot active.		
	invalid or not active		
	and/or Submitter ID is		
_	or org. name invalid		
-	Submitter's last name	Inb837.Post.3	Verify Submitter
error should not occur with DDE users.			
and Payer Primary Identifier. This denial pertains to SFT/EDI users. This			
DMH. Identification information must consist of: Payer Name, Id Qualifier	w/DMH.		
In EDI/SFT claims, verify that the payer referenced on the inbound claim is	Payer is invalid not	Inb837.Post.11	Payer
at (213) 738-3311 to assist with further research.			NOLL
This could also be from system issues. Contact the Provider Relations Unit			
Could be an unhandled exception. Need to view on a case by case basis.			
is in the appropriate state to perform the voit of Nesato.			
or denied. Ensure that the original claim has been processed properly and			
submit a claim, the prior claim must have been accepted and either voided			
accepted into the system, then a void transaction is not valid. In order to re-			
status other than submitted or denied. If the original claim was not			
In order to void a claim, the original claim must be in the system with a		Inb837.Post.5a	Prior ClaimID For
DESCRIPTION/RESOLUTION	DESCRIPTION	RULE #	DENIAL REASONS
	Y		

DENIAL REASONS	RULE#	DENIAL	DESCRIPTION/RESOLUTION
		DESCRIPTION	
Verify FFS 2 Plan	Inb837.Post.30	FFS plan code was	Verify that the MCF plan code is correct. The correct plan code is 1001.
		invalid.	This pertains to SFT/EDI users. This error should not occur with DDE
			users. (2330A_REF02=1001). Contact the EDI/SFT Technical Support
Verify Time Limits	Inb837.Post.16	Service cannot	FFS Netork Provider must ensure the service time does not exceed more
n		exceed more than 24	than 24 hours. (no more than 1440 minutes).
		hours.	
Verify Receiver	Inb837.Post.6	Receiver code is	The receiver of all claims must be DMH. DMH receiver ID should be valid
		invalid.	and used. See Companion Guide:
			http://dmh.lacounty.info/hipaa/ffs_SecureFile.htm. This error pertains to
			Technical Support Group at (213) 251-6618 if more details are needed.
Validate Client has not been Inb837.Post.48 cross referenced	Inb837.Post.48	Client ID has been crossed with another	Verify the subscriber ID is a valid person's record that has not been cross referenced with another person's id. This function needs to be addressed by
		7e130110#.	enables them to view the client cross-reference records. In order to verify
10			this information, a Helpdesk associate (213-351-1335) needs to log in to the clinical application and view the details of the client in question.
Verify DateTime string	Inb837.Post.51	Date not in	The date must be consistant with date qualifer and in the format of
w/Date Qualifer		yyyy/mm/dd format.	11
			DDE users. Contact the EDI/SFT Technical Support Group if more details are needed
Verify Service Time	Inb837.Post.45	Service unit count	Verify and/or correct the service minutes to ensure there is not a zero (0) or
		was less than 1.	a negative number entered.
Verify Void Claim	Inb837.Post.5	Original or	FFS Network Providers are to ensure that if the claim is voided or
2		resubfilited claim	resubmitted, the voided claim has an original inbound claim previously
		does not exist or is	submitted in the IS. In order to void a claim, the original claim must be in the
		or o	was not accepted into the system, then a void transaction is not valid.